

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3309 Harrison Str., K.C. Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 13 Years.
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Evaline Lawson, 250

3. (b) If veteran, name war None 3. (c) Social Security No. No.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife Calvin Lawson 6. (c) Age of husband or wife if alive Widow years
7. Birth date of deceased Jan. 17th, 1852
(Month) (Day) (Year)

8. AGE: Years 87 Months 2 Days 6 If less than one day
hr. min.

9. Birthplace Missouri (City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business

12. Name Henry Young, 9
13. Birthplace Unknown (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Mary Barnhart,

(b) Address 3303 Harrison Str., K. C. Mo.

17. (a) Burial (b) Date thereof March 25 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shipped body to Meta, Mo. 3-25-40

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address 918 Brooklyn Avenue, K. C. Mo.

19. (a) Mch 24, 1940 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 3309 Harrison, K. C. Mo.
(If rural, give location)
(e) If foreign born, how long in U. S. A? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 23rd, 1940
year 1940 hour minute 5:30 A.M.

21. I hereby certify that I attended the deceased from Mar 22, 1940 to Mar 23, 1940
that I last saw her alive on Mar 22, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumonia, Bronchial
Due to Smoking 107 hr
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) Means of injury

23. Signature Higha Rusting (M.D. or other)
Address 303 Hurstman Date signed 3/23/40

Dr. Gestring,
Office Myra Thacker
Phone 212-6444

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____,
_____, Registered Apprentice No. _____,
working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.